



State Health Watch

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The Newsletter on State Health Care Reform

September 2007



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Documentation rule hurts Medicaid-eligible citizens: Report from the GAO

According to a Government Accountability Office (GAO) report, U.S. citizens who appear to be eligible for Medicaid have faced significant access problems due to the new citizenship documentation rule, which was intended to weed out illegal aliens and not to punish U.S. citizens. In a separate report, the Virginia Health Care Foundation said there has been a large drop in Medicaid enrollment since the rule was implemented, while enrollment in SCHIP, which does not use the rule, has continued to grow.

GAO was asked by Reps. John Dingell (D-MI), chairman of the

House Energy and Commerce Committee, and Henry Waxman (D-CA), chairman of the House Oversight and Government Reform Committee, to examine how the requirement, which was approved as part of the Deficit Reduction Act of 2005, has affected individuals' access to Medicaid benefits and to assess the administrative and fiscal effects of implementing the requirement.

GAO surveyed Medicaid offices in the 50 states and the District of Columbia about their perspectives on access issues and the requirement's administrative and fiscal effects.

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Fixing the health care payment system: Care and payment based on clinical guidelines

While health care fee-for-service and capitation payment systems have been with us for many years, they have significant well-known flaws. Thus, fee-for-service payments, in which a separate fee is paid for each service rendered, has been tied to the rapid increase in the cost of health insurance premiums, while capitation's flat fee per patient can put providers at risk by providing insufficient funds to cover the costs of providing needed services. Researchers

say that in the United States both fee-for-service and capitation have failed to promote coordination among providers or high-quality outcomes for patients.

A nonprofit corporation known as Prometheus Payment has developed a new payment model based on what it calls evidence-informed case rates (ECR). The model attempts to address the problems with fee-for-service and capitation. Prometheus defines an ECR as a single, risk-adjusted, prospective or retrospective payment given to providers across

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**Fiscal Fitness:
How States Cope**



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Documentation

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Complete responses were obtained from 44 states (71% of national Medicaid enrollment in FY 2004). GAO also reviewed federal laws and regulations and guidance to states issued by the Centers for Medicare & Medicaid Services (CMS).

The Deficit Reduction Act provision in question requires states to obtain satisfactory documentary evidence of U.S. citizenship or nationality for nearly 40 million nonexempt Medicaid beneficiaries within one year of the provision's July 1, 2006, effective date, as well as for new applicants to the program, who constitute an estimated 10 million people annually.

GAO reports that while U.S. citizenship or satisfactory immigration status has long been a requirement for Medicaid eligibility, individuals in most states could previously attest to their citizenship status in writing under penalty of perjury. But self-attestation of citizenship is no longer acceptable. Instead, the Deficit Reduction Act requires that states implement an effective process for documenting citizenship to obtain federal Medicaid matching funds. CMS issued an interim final rule outlining a prescriptive process states must follow to obtain satisfactory documentation of citizenship for Medicaid applicants and existing beneficiaries and identifying a list of acceptable documentation.

Several concerns raised

States and advocacy organizations have raised concerns about the requirement, saying the need for it has not been established, that efforts to comply with it will result in eligible citizens losing access to Medicaid coverage, and that it will be costly for states and individuals.

GAO said states reported the requirement resulted in barriers to access to Medicaid, such as delayed or lost coverage for some eligible individuals. Some 22 of the 44 states reported declines in Medicaid enrollment due to the requirement, and a majority of these states attributed the enrollment declines to delays in or losses of Medicaid coverage for individuals who appeared to be eligible citizens. Of the remaining states, 12 reported the requirement had no effect on enrollment, while 10 reported that they did not know the requirement's effect on enrollment.

Though states often cited a combination of reasons for the decline in Medicaid enrollment, when asked the primary reason, 12 of the 22 reported that enrollment declined because applicants who appeared to be eligible citizens experienced delays in receiving coverage. In addition, five of the 22 states identified the primary reason for the enrollment declines as current beneficiaries losing coverage, with four of the five states saying the individuals appeared to be eligible. Two states said declines were largely driven by denials in coverage for individuals who did not prove their citizenship. GAO said it was unclear from survey results whether these individuals were determined ineligible because in fact they were not citizens or because they did not provide the required documents within the timeframes allowed by the states. Two of the remaining three states reported that the primary reason for the decline was that individuals were discouraged from applying because of the requirement or were not responding to states' requests for documentation of citizenship.

Not all of the 22 states reporting enrollment declines as a result of the requirement could quantify the

decline; however, one that had begun tracking the effect identified 18,000 individuals in the first seven months of implementing the requirement whose applications were denied or who had coverage terminated due to the inability to provide the necessary documentation, although the state generally believed them to be eligible citizens. While not explicitly tracking the effect of the requirement on enrollment, 10 other states that attributed enrollment declines at least in part to applicants who were delayed or denied coverage also reported increases in monthly denials ranging from 1% to 14% after implementing the requirement.

Will enrollment decline continue?

States reporting an enrollment decline varied in their impressions of the requirement's effects on enrollment beyond the first year of implementation, GAO said. Of the 22 states that reported an enrollment decline, 17 said they expected the downward trend to continue, while five said the declines would level off within about one year of implementation. Ten of the 17 states said they were unsure how long enrollment declines would continue or generally expected the trend to continue indefinitely. A few of these states noted concern about the ongoing effect on new applicants who will be unfamiliar with the requirement and may be denied enrollment or discouraged from applying. The remaining five of 22 states said they did not expect the decline to continue.

The requirement's effect on individuals' access to Medicaid could have been influenced by state enrollment policies and whether an individual was an applicant or an existing beneficiary. For example, the report said, states that relied primarily on mail-in applications before implementing the requirement were

more likely to report enrollment declines than were states where individuals most frequently applied in person. Also, the requirement may affect Medicaid applicants more adversely than beneficiaries because applicants in some states were given less time to comply and were not eligible for Medicaid benefits until they documented their citizenship.

Although states have invested resources to implement the requirement, potential fiscal benefits for the federal government and states are uncertain, according to GAO. All 44 states reported taking a number of administrative measures, such as training eligibility workers and hiring additional staff, to implement the requirement and help individuals comply.

Also, 10 states reported that a total of \$28 million was appropriated for the requirement in state FY 2007, and 15 states budgeted funds for state FY 2008. But despite these measures, states reported that the requirement resulted in the state spending more time completing applications and redeterminations and individuals needing more assistance in person during the process.

Two particular problems

States said that two aspects of the requirement in particular increased its burden on individuals and states: 1) documents must be originals; and 2) the list of acceptable documents is complex and does not provide for exceptions. For example, states reported that individuals who previously would have applied for Medicaid through the mail will not part with original documents such as drivers' licenses, and instead are presenting them in person, which increases the workload of state eligibility workers.

Of the 35 states that reported increases in processing time, most said the requirement added five or

more minutes per case to the processing time for applications and redeterminations. While only one of the 35 states expected an increase of less than five minutes per case, nine states estimated an additional five to 15 minutes per case, and 16 states expected the requirement to add more than 15 minutes of processing time per application or redetermination, well above the CMS estimate of five minutes per case.

One state reported processing an average of more than 150,000 applications per month in the eight months following implementation. In that state, GAO said, assuming an increase in processing time of a minimum of 16 minutes per application, implementing the requirement would have added at least 40,000 hours of staff time per month.

Other states emphasized that the effect of the requirement on workload goes beyond the amount of time needed to complete applications and redeterminations. Thus, one state reported a 60% increase in phone calls, a tenfold increase in voice messages, and an 11% increase in the amount of time spent on each call.

CMS reported it has taken a number of steps to minimize the administrative burden, including substantially expanding the list of acceptable documents.

While CMS estimated the requirement would result in savings of \$50 million for the federal government and \$40 million for states in FY 2008 as a result of terminations of eligibility for noncitizens inappropriately receiving Medicaid benefits, states said the CMS estimate may be overstated because it did not account for increases in administrative expenditures reported by states and the intended effect of the requirement—to prevent ineligible noncitizens from receiving Medicaid benefits—may be less prevalent than CMS expected.

In reviewing the GAO report, CMS said it did not disagree with the study's approach, but said it had several concerns about the sufficiency of the underlying data for, and certain aspects of, the GAO findings.

In particular, CMS characterized the report's conclusions as overstating the effect of the requirement on enrollment, and stated it had concerns about the fact that the states did not submit data to substantiate their responses to the survey questions on which the GAO findings were based. CMS also expressed concerns that the draft report it was shown appeared to draw broad conclusions about the effect of the requirement from data provided by just one state.

GAO defended its work, saying the goal was to report on the initial effects of the requirement, and noting that while not all states could quantify the requirement's effect on enrollment, 22 states reported that the requirement resulted in decreases in enrollment, 12 reported it had no effect on enrollment, and 10 said they did not know the effect.

"Absent national CMS data on the effects and because state Medicaid offices were largely responsible for implementing the requirement, we determined they were the best source for this information," GAO said. "...We disagree with CMS' assertion that the draft report drew broad conclusions about the effect of the requirement on enrollment from one state's data. The report clearly indicates that these data are from a single state and further notes that the extent of the decline in Medicaid enrollment due to the requirement in some individual states and nationally is unknown."

In response to the finding that two aspects of the requirement—

that documents be originals and that the list of acceptable documents is complex and does not allow for exceptions—presents challenges to states and individuals, CMS said the agency has attempted to provide as much flexibility as possible, and noted that other federal agencies require original documentation.

"Nevertheless," GAO said, "our survey results clearly indicated that these two aspects of the requirement are viewed by most states as posing barriers to access. In particular, 42 of 44 states reported that having to provide original documentation posed a barrier to eligible citizens meeting the requirement, and 34 states reported that an individual's inability to provide documents other than those defined under federal regulations by CMS created a barrier to compliance. Further, while the report explains that CMS modeled its regulations after the Social Security Administration's policy for documenting citizenship when individuals apply for a Social Security number, the report also notes that, unlike CMS, the Social Security Administration provides for flexibility in special cases."

Savings figures in question

CMS said it agreed that its estimate of potential savings in FY 2008 did not account for administrative costs incurred by states to implement the requirement, but added that any such costs would decrease after the first year of implementation. GAO said its report describes that some states reported not having budgeted funds for the requirement in future years and explains that one reason for this may be that the burden of the requirement may decrease after the first year of implementation. However, it added, the ongoing costs of assisting applicants in complying with the requirement may continue to be

significant in some states, especially those states that had to substantially modify their enrollment procedures.

CMS commented it was not surprised that states reported facing challenges, GAO said, given that the report's findings were based on states' experiences after less than one year of implementing the requirement. The agency said the initial challenges have diminished and will continue to do so.

But GAO responded that based on the survey results, state do not share CMS' optimism that the challenges are diminishing. "In addition to describing the initial effects of the requirement, which in states' perspectives have included enrollment declines and increased administrative burdens," GAO said, "our report includes additional indicators that the effects states experienced in the first year will continue at least to some extent in the future. For example, 17 of 22 states that reported a decline in enrollment due to the requirement reported that they expected the downward trend in enrollment to continue, with some expecting the decline to continue indefinitely. In addition, 15 states reported already having budgeted funds for the requirement in state fiscal year 2008."

Meanwhile, the Virginia Health Care Foundation says the new requirement has had a much broader impact in that state than anticipated, adversely affecting thousands of citizen children since its July 2006 implementation. In a report, the foundation says unintended consequences include: 1) a significant decrease in the number of children enrolled in Medicaid in Virginia; 2) delays of four to six months in obtaining Medicaid coverage for Virginia children; 3) inability of citizen children to obtain medical care; and 4) a dramatic increase in emergency department (ED) use by

families caught up in lengthy eligibility determinations. And the foundation says the requirement also has increased costs and administrative burdens to state and local government agencies, which have required additional tax dollars.

Drop in Medicaid children

After years of steady growth and an average net increase of 1,000 children per month in the 12 months immediately preceding implementation of the new requirement, there has been a dramatic decline in the number of children enrolled in Virginia's Medicaid program, the foundation says. Specifically, there was a net decrease of 11,108 children enrolled in Medicaid in the first nine months of implementation of the documentation requirement.

To demonstrate that the documentation requirement appears to be the culprit, the foundation says that in the same time period the monthly net enrollment of children in Virginia's SCHIP program continued to increase. (SCHIP does not require original documents to prove citizenship and identity.)

"Given the similarities in the two programs, and the continuous growth in SCHIP, it is reasonable to conclude that enrollment in Virginia's Medicaid program would have continued increasing as well, in the absence of the new requirement," the foundation says. "In fact, at the pre-regulation rate of monthly net increase (1,000), an additional 9,000 children would now be enrolled in Medicaid. When the impact of decreased Medicaid enrollment (11,108) and the elimination of monthly growth (9,000) are combined, more than 20,000 Virginia citizen children have been adversely affected and unintentionally affected during the first nine months of the new requirement."

Foundation deputy director **Judith Cash** tells *State Health Watch* no one has challenged the report's indication that the documentation requirement is the cause of Medicaid declines while SCHIP continues to enroll more people.

The foundation commissioned a telephone survey of 800 adults who applied for Medicaid for their citizen children after the requirement was implemented and says the survey "documents a variety of troubling and unintended consequences."

First, the survey found that more than half of the children who were not yet enrolled at the time they were surveyed had been waiting for four months or more for their applications to be processed. For those who were enrolled at the time of the survey, the report says, 72% required more than the allowable 45 days to process, with 21% taking more than 76 days. The foundation says such delays are atypical for Virginia's Central Processing Unit, which needed an average of 16 days to process a child's Medicaid application in the six months before the documentation requirement was implemented.

ED use increasing

While waiting for the enrollment to be approved, 90% of those surveyed said they had no other health care coverage for their child and of that 90%, 65% said they needed some type of health care during the waiting period. Some 41% of the children who needed care were not able to get all of the care they needed. The reason parents most often gave for being unable to obtain health care for their children was that they couldn't afford it (72%).

In addition, the foundation found, there was a significant increase in use of hospital EDs for primary care by parents who said

they do not normally use the ED as their usual source of care.

The foundation also documented the impact of the requirement on state and local agencies administering the program. At the state level, the Central Processing Unit's "pending cases" file (those awaiting further documentation) went from about 50 a month before the new requirement was implemented to 4,000 in January 2007. To address the backlog, the Central Processing Unit hired seven additional staff and provided accompanying space, phones, and computers at a first-year additional cost of more than \$144,000. Virginia officials also are paying \$25-\$50 each to obtain out-of-state birth certificates. The foundation reports that in the first six weeks of the new requirement, local departments of social services received 900 requests for assistance in obtaining out-of-state birth certificates.

Ms. Cash tells *SHW* the foundation has shared the information it developed with the state congressional delegation and with CMS. She notes the issue came up as the Senate discussed SCHIP reauthorization and actually included a provision that would make use of Social Security numbers to document citizenship and would leave it to the states to decide how to use the numbers. She said the foundation was "pleased" with that proposal, noting that the ultimate goal of the survey and other efforts has always been to have the documentation requirement eliminated. (As this issue of *SHW* was being prepared, it was not known whether that provision would survive in the final version of the bill and whether the president would veto any SCHIP legislation.)

Virginia's Medicaid agency also has been in touch with the state's congressional delegation and CMS to discuss the drop in enrollment,

Ms. Cash tells *SHW*.

She says the organizations will now “continue to wait and watch and see what happens with enrollment. We’ve shared some possible strategies with eligibility workers and we’ll see how they work out. We

hope the GAO report will give additional emphasis to the issue and people will pay more attention to it.”

Download the GAO report at www.gao.gov/cgi-bin/getrpt?GAO-07-889. Access the Virginia Health Care

Foundation report at www.vhcf.org. More information on the Virginia report is available from the foundation’s Judith Cash at (804) 828-5804 and from the Virginia Department of Medical Assistance Services’ Cindi Jones at (804) 786-4626. ■

Fiscal Fitness

(Continued from cover)

inpatient and outpatient settings to care for a patient diagnosed with a specific condition. Payment amounts are based on the resources required to provide care as recommended in well-accepted clinical guidelines.

Bridges to Excellence national coordinator **François de Brantes**, who is a member of the Prometheus Payment core design team, tells *State Health Watch* the group is working at a time when there is considerable interest in payment reform along with broader health care reform.

“I think the country is going to run out of patience if there isn’t a good solution for our healthcare system in sight by 2010,” Mr. de Brantes says. “Stakeholders don’t want full nationalization or major price controls. We have an opportunity over the next two to three years to start heavy experimentation to see if there is a free-market approach that works. I think that if we can’t succeed, significant controls are inevitable.”

Prometheus Payment is specifically designed to: 1) improve quality; 2) lower administrative burden; 3) enhance transparency; and 4) support a patient-centric and consumer-driven environment, all while facilitating better clinical coordination throughout health care.

The tenets of Prometheus Payment state that:

- providers have an opportunity to negotiate meaningfully their payment amounts in accordance with

the evidence-informed case rate and clinical practice guidelines;

- no one receives a provider’s payment unless the provider bargained to be paid through another party;
- mechanisms of payment and systems of reporting are transparent and public;
- providers have the option to configure themselves in whatever arrangements they choose;
- the implementation of Prometheus explicitly seeks to lower administrative burden wherever possible;
- providers measured for efficiency will have information about other providers in order to facilitate effective referral choices;
- providers have the opportunity to speak to scorecard issues such as data findings, before they are made public.

To further promote quality care, the Prometheus ECR model calls for a portion of the payment to be withheld and redistributed based on provider performance on measures of clinical process, outcomes of care, and patient experience with care received.

Developing ECR models

Prometheus has been developing models of how the ECR payment system would work by convening five working groups that included medical professionals, health care researchers, and data modeling experts. The working groups selected 10 conditions for ECR development, looking at criteria such as prevalence, costs, treatment variation, coordination, and reimbursement. They are developing each ECR’s scope by

examining issues such as the standard work-up required to diagnose the condition, the services that should be covered by the ECR, and criteria for successful completion of care.

The initial conditions chosen were colon cancer, nonsmall-cell lung cancer, mitral valve regurgitation, nonischemic Stage C congestive heart failure, ST-segment elevated myocardial infarction, depression, Type 2 diabetes, knee replacement, hip replacement, and all preventive care.

Groups were charged with:

- choosing the conditions for ECR development;
- selecting clinical practice guidelines for those conditions;
- determining the natural boundaries of each ECR;
- providing a rigorous estimate of the ECR base;
- including the total units of service and the type of provider responsible for delivering those services;
- establishing a reasonable set of performance measures that should be used to evaluate the clinical performance of providers delivering the services included in the ECR;
- participating in and supervising the data modeling of the ECR to determine the extent to which results were valid;
- creating estimates for the warranted variation of services that should be added to the base.

Selection criteria for the 10 initial conditions chosen for ECR development included conditions with high prevalence or high cost per event, situations in which there is wide variation in treating the condition,

treatment that requires coordination among multiple providers, treatment that requires services that are not currently reimbursed, the condition has clear boundaries, and clinical practice guidelines exist for the condition.

Mr. de Brantes says the knee transplant ECR has been completed, work is well under way on the diabetes ECR, and work is getting started on the ECR for all preventive care.

The goal of ECRs is to limit both under- and overuse, eliminate unwarranted variation, reduce risk selection problems that occur when providers receive the same payment to treat different types of patients, promote clinical integration between providers across disparate settings, and deliver recommended, high-quality care.

Pilot sites to be chosen

Later this year, Prometheus will move the project forward by selecting up to four pilot sites and working with local stakeholders to prepare each site for implementation. Candidates included Brockton, MA; Chicago; Memphis, TN; Philadelphia; and San Francisco. Prometheus also expects to develop an additional 50-60 ECRs during the next three years to increase the scope of the pilots and cover an increasing portion of the total care delivered in any community.

To help prepare for the pilots, which are scheduled to open Jan. 1, 2008, Prometheus has been working with additional partners on the infrastructure that will be needed to help plans and providers work through the payment model.

"This is not an easy model for plans and providers to implement because their current systems are based primarily on the fee-for-service system and they are not geared to track what needs to be tracked for

an ECR," Mr. de Brantes says. He says Prometheus will not be able to provide the infrastructure free to plans, but will try to keep the cost as low as possible.

Prometheus says that while work to date has shown it is possible to create a working set of ECRs, it remains to be seen whether the product can successfully achieve its ends—a limitation on physician-induced demand, a reduction in risk-selection problems, promotion of clinical integration, and delivery of recommended, high-quality care.

According to Mr. de Brantes, the concept has drawn interest in two different areas. First, there are some communities that already have been very innovative in delivering health care and are interested in trying to move toward an integrated payment system. And second, some larger delivery systems have expressed an interest in pricing care under a global rate structure. That came about partly, he says, because a Commonwealth Fund report on the Prometheus project came out at about the same time as media attention was directed to an effort by Geisinger Health System in Pennsylvania to standardize care for elective heart bypass surgery and charge a flat fee that includes all necessary follow-up care for 90 days after surgery.

Geisinger's bypass experience

In reassessing how they perform bypass surgery, Geisinger doctors identified 40 essential steps. They then put procedures in place to ensure the steps are always followed no matter which surgeon is involved and which of the system's three hospitals is involved.

When the effort, known as ProvenCare, began in February 2006, Geisinger was performing all 40 bypass surgery steps only 59% of the time. For the last seven months,

the system says, its teams have managed to have a perfect record in following all recommended steps for surgery and follow-up care. The system now is looking at developing similar approaches for other kinds of care, like hip replacements, where there is much less medical agreement on what constitutes best practices.

At the same time, the system is looking into whether purchasers would be interested in this type of approach—the same question Prometheus is asking. Heart surgery and follow-up care at Geisinger runs about \$30,000. Under the experiment, the hospital charges a flat fee for the surgery plus half the amount it has calculated as the historical cost of related care for the next 90 days. Instead of billing for any additional hospital stays, which typically cost \$12,000-\$15,000, Geisinger absorbs that extra cost.

When the system presented results of the first year of its experiment at an American Surgical Association meeting earlier this year, it said patients have been less likely to return to intensive care, have spent fewer days in the hospital, and are more likely to return to their own homes instead of going to a nursing home.

Elsewhere in the U.S. health care system, missing an antibiotic or giving poor instructions when a patient is released from the hospital results in a perverse reward—the chance to bill the patient again if more treatment is necessary. As a result, doctors and hospitals have little incentive to ensure they consistently provide the treatments that medical research has shown lead to the best results.

In a report on the Geisinger experiment, the *New York Times* noted that many modern industries worldwide, including the manufacture of cars and computer chips, understand the importance of improving each step in the production process as a way of

holding down costs and improving quality. The newspaper quoted Pacific Business Group on Health medical director **Arnold Milstein**, MD, MPH, as saying that hospitals have been slow to focus their attention on standardizing the way they deliver care. Geisinger, he said, "is one of the few systems in the country that is just beginning to understand the lessons of global manufacturing."

'Learning network' to open soon

Mr. de Brantes says several other large integrated systems have contacted Prometheus expressing interest in working together on how to price care under a global case rate structure. He says Prometheus is

interested in putting together a health system "learning network" within 60 days to facilitate the exchange of information and ideas.

Asked what it will take to make ECR a reality, Mr. de Brantes says the single biggest obstacle will be the fact that the entire U.S. health care system is based on volume rather than results. Billing is based on units of service, he says. That is the single biggest challenge and it will be easiest to overcome through integrated delivery networks.

Ultimately, he says, the key to success will be to help the everyday hospital that is not integrated with a large medical group and the individual physician practice to start thinking

and behaving differently. "They need to understand that they have to behave as a team," he tells *State Health Watch*. "A new payment mechanism will force them to think as though they are integrated, even though they aren't. There are many examples of this working in other sectors of the economy."

More information is available online at www.prometheuspayers.org/. Download the Prometheus White Paper at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=478278. Contact Mr. de Brantes at francois.debrantes@bridgestoexcellence.org. ■

Legislation would change CMS pharmacy rule

Spurred by complaints from the National Community Pharmacists Association (NCPA), the National Association of Chain Drug Stores (NACDS), and other pharmacy interests, some members of Congress are backing legislation to fix what they say is a flawed Center for Medicare & Medicaid Services (CMS) Medicaid pharmacy reimbursement rule for generic drugs.

Reps. Nancy Boyda (D-KS), Jo Ann Emerson (R-MO), and 30 other House Democrats and Republicans have introduced HR 3140, the Saving Our Community Pharmacies Act of 2007, which would make four changes to the CMS Medicaid generic prescription drug pharmacy reimbursement formula. Pharmacy groups have said the CMS plan would force many community pharmacies to either limit the amount of Medicaid services they can provide, drop Medicaid completely, or even go out of business.

Although CMS has delayed implementation of the new formula, pharmacies continue to say it is ill-advised.

The formula is based on the average manufacturer price (AMP) from the 2005 Deficit Reduction Act's mandate to find \$8.4 billion in Medicaid cuts, with 90% of that total coming from pharmacy reimbursement.

NCPA says that goal was achieved by including several pricing categories that push down the typical drug acquisition costs to disperse drugs well below what community pharmacies actually pay. The association says since Medicaid is intended to meet the health care needs of poor and disabled Americans, half of whom are children, the prospect of community pharmacies struggling to be financially viable creates a slippery slope. When these vulnerable patients' access to prescription drugs is limited, NCPA says, their health will be endangered and expensive visits to emergency departments and doctors' offices will increase.

HR 3140 would:

- redefine the pharmacy reimbursement benchmark to accurately reflect pharmacy acquisition costs;
- exclude all sales to mail-order

facilities and any pharmacy benefit manager rebates and price concessions that are not available to retail pharmacies;

- properly define the retail class of trade to only include retail community pharmacies;

- include provisions to drive generic utilization, which would increase taxpayer and government savings.

NCPA says without HR 3140 becoming law, estimates from the Government Accountability Office and NCPA are that the total net profit for the average community pharmacy would fall by 60% under the CMS rule. Community pharmacies are said to receive 92% of their revenue from prescription drugs, which means these types of losses cannot be made up through other revenue sources.

Critical for continued access

"This bipartisan legislation is critical to maintaining patient access to their trusted community pharmacists who will provide medical advice and fill their prescription drug needs,"

said NCPA president **John Tilley**, RPh, a Downey, CA, pharmacy owner. "Without Congress acting in an expeditious fashion, many more communities will see their access to life-saving prescription drugs jeopardized. This doesn't just affect Medicaid patients. A closed pharmacy means all of its patients lose, which is an outcome CMS will have created by not heeding the warnings of Congress, NCPA, and other business and health care organizations who have long understood that the AMP formula would have devastating consequences."

A CMS update on the new rule says the Deficit Reduction Act changes were prompted by a series of 2004 reports by the Government Accountability Office and the HHS Office of the Inspector General (OIG) that indicated that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies were actually paying for the drugs. Those agencies said states were overpaying for drugs because they were using commercial drug pricing guides as the basis for setting state reimbursement levels.

The new formula establishes a federal upper limit (FUL) calculation, which is the maximum the federal government will pay to states in federal matching funds or federal financial participation for generic drugs dispensed through state Medicaid programs. The new FUL is calculated at 250% of the lowest AMP in a generic drug class. States may pay above or below the FUL for individual drug classes and still receive the full federal financial participation as long as overall payments for generic drugs subject to an FUL are under the annual aggregate cap.

While the law requires CMS to set an FUL, states retain the authority to set their own reimbursement levels and dispensing fees paid to pharmacists. Recognizing that the

new FULs could result in some reduction in drug ingredient payments to pharmacies, CMS officials have said they are actively encouraging states to evaluate whether the fees they pay pharmacies are adequate to compensate them for their costs in dispensing prescriptions. It has been reported that Iowa and Kansas have agreed to transfer any savings resulting from the new rule to pharmacy dispensing fees. Also, Texas plans to increase its dispensing fee to at least \$7.50, with triggers that could increase the fees to \$12.50. The average dispensing fee nationwide is about \$4.50.

States may help pharmacies

Morgan Stanley analyst **David Veal** told investors that the six-month delay announced by CMS will move implementation of the rule much closer to the time that many state legislatures reconvene and "potentially allow[s] lawmakers to boost dispensing fees more immediately to offset the potential reimbursement cuts."

Ammunition for the pharmacies' position came in an HHS Inspector General report that said the new FUL may force states to underpay pharmacy providers for generic medicines they dispense under Medicaid. Pharmacy acquisition costs will exceed the FUL for 19 of the 25 high-expenditure Medicaid drugs studied, the OIG report said. The report also found that for 12 of the 19 drugs studied, the average pharmacy acquisition costs "would have been more than double the reimbursement limit."

"This report confirms the serious concerns raised by community pharmacy, the Government Accountability Office, other Inspector General reports, and the 250 members of Congress who have gone on record in letters to CMS or HHS," said NACDS

CEO **Steven Anderson**. "Rather than reflecting actual pharmacy drug costs, the reimbursement limits currently proposed by CMS would dramatically limit the availability of community pharmacy services to millions of Medicaid beneficiaries."

The OIG report said that the lowest AMP for 109 of the 521 drugs it looked at comes from a drug with very limited distribution (2% or less of Medicaid sales). The report also said 149 of the 521 drugs (29%) have FULs based on the lowest AMP that would be below the amount that they assume most pharmacies could buy at, on average."

The OIG report said when CMS sets a new FUL, it "should take steps to identify when a new federal upper limit amount may not be representative of a drug's acquisition cost to pharmacies." The report also said CMS should give pharmacies the opportunity to alert the states and CMS when they can demonstrate they are not able to purchase a drug at or below the new FUL amount."

At a House Committee on Small Business hearing, committee chair **Nydia Velázquez** (D-NY) said the CMS rule "will have serious consequences for privately owned pharmacies, as well as the people who depend on these businesses for their medical supplies and prescriptions. It is clear that CMS failed to take into account the domino effect that this new rule will have on small pharmacies and the communities they serve. Once again, it is our nation's small businesses that are being forced to carry the sole burden of a proposal such as this one. This is not right. We will be working to ensure that CMS assesses the impact on small pharmacies, a simple yet critical step that CMS has failed to do." ■

AHRQ: State gains in health care quality seen

States have made promising gains in health care quality, although more remains to be done in areas ranging from cancer screening to treatments of heart attack patients, according to new state snapshots released by the federal Agency for Healthcare Research and Quality (AHRQ). The Internet-based state snapshots tool was launched in 2005 as a way to help state health leaders, researchers, consumers, and others understand the status of health care quality in individual states, including each state's strengths and weaknesses.

The snapshots cover each of the 50 states plus the District of Columbia and are based on 129 quality measures that each evaluate a different segment of health care performance. AHRQ says the measures are products of complex statistical formulas, but are shown on the web site as simple five-color "performance meter" illustrations.

For a subset of 15 "State Rankings for Selected Measures," chosen to represent a broad range of common diseases, the State Snapshots highlight specific state strengths. Thus, New York ranks best for its low suicide rate, while

Montana ranks first for pneumonia vaccinations for seniors, and Utah is first for its low colorectal cancer death rate. No state is good at everything and the State Snapshots point out areas where states need improvement, officials said.

The data in the snapshots are drawn from AHRQ's 2006 National Healthcare Quality Report. They come from various data sources covering multiple years. AHRQ officials said the statistics provide state-specific information but also underscore the reality that some health care shortcomings are widespread. On average, for example, states reported that only 59% of adult surgery patients covered by Medicare receive appropriate timing of antibiotics. And only 54% of men older than age 50 reported they ever had a flexible sigmoidoscopy or colonoscopy, according to the all-state average. Only about 54% of Medicare managed care patients said their health care providers always listened carefully, explained things clearly, showed respect for what they had to say, and spent enough time with them.

The State Snapshots provide summaries that measure health care

quality in three different contexts—type of care such as preventive, acute, or chronic care; care settings such as nursing homes or hospitals; and care by clinical area such as care for patients with cancer or respiratory diseases. The 129 quality measures range from preventing bedsores to screening for diabetes-related foot problems to providing antibiotics quickly to hospitalized pneumonia patients. The snapshots allow users to compare a state's performance against other states in the same region and against "best-performing states."

"It is clear that the nation must continue pursuing important opportunities to improve the quality of health care," said AHRQ director **Carolyn Clancy, MD**. "The State Snapshots help policy-makers understand the breadth of those problems and how their states compare with others. With that knowledge, they are better equipped to take vital steps that will improve the health of people in their states."

The State Snapshots are available online at <http://statesnapshots.ahrq.gov>. ■

Study: Subsidies don't greatly boost insurance coverage

ARAND Corp. study says government subsidies to cut health insurance premium prices by 50% for those without insurance would only cut the number of uninsured Americans by 3%.

RAND officials said their study contradicts suggestions that large numbers of people without health insurance would sign up for coverage if the government provided subsidies or tax credits to reduce health insurance cost.

"Insurance policy prices aren't going to be the tool that solves the

problem of the uninsured," said RAND senior economist **M. Susan Marquis**, one of the study's authors. "Price is not the only barrier people face in deciding whether to purchase insurance. A lot of people who don't have insurance are young and healthy and would rather spend their money on something else."

Those surveyed for the RAND study cited numerous other factors that influenced whether they purchased individual health insurance policies, including personal attitudes toward risk, whether they believe

they can get good health care without insurance, perceived difficulty in selecting a health care plan, and even a concern that insurance companies require too much personal information for individual plans compared with group insurance plans.

"One implication of our findings is that if you really do want to get universal health insurance coverage, voluntary solutions that rely on financial incentives aren't going to get you there," Marquis said. "Government is probably going to have to mandate it."

The study found that among people who decide to buy nongroup health insurance, price is an important factor in their decision to choose one policy over another. The researchers said people who buy health insurance prefer policies with

more benefits and lower deductibles, even if they have to pay higher premiums. Those in poor health are particularly willing to pay a higher price for a low deductible, and are more likely to prefer insurance plans that feature mental health and

prescription drug benefits. The researchers said newer types of individual plans with high deductibles may be attractive to healthy people, but are not likely to help reduce the total number of people without health insurance. ■

March of Dimes Report Card: Newborn screenings up

The percentage of newborns living in states requiring screening for at least 21 life-threatening disorders has more than doubled since 2005, according to the latest March of Dimes Newborn Screening Report Card. The Report Card says nearly 90% of babies born in the United States are in states requiring the screenings. But 500,000 babies still are not screened for serious genetic disorders.

The American College of Medical Genetics has recommended that every U.S. newborn be screened for 29 genetic or functional disorders. If diagnosed early, it says, each of the conditions can be successfully managed or treated.

Two years ago, the March of Dimes says, 38% of infants were born in states requiring screening for at least 21 of the core 29 conditions. As a result of four years of advocacy by March of Dimes chapters, partners, and parents, it says, the percentage has increased to 87.5% or some 3.6 million babies.

While this expansion of newborn screening is good news for families, the lives of 500,000 newborns still hang in the balance," said March of Dimes president Jennifer Howse, PhD. "The United States lacks federal guidelines for newborn screening. Babies must be screened to receive treatment necessary to survive and lead healthy lives. The lack of federal guidelines makes it difficult for states to get support for needed legislation."

Currently, Dr. Howse said, 13

states and the District of Columbia require screening for all 29 conditions. (A list of screening tests each state provides is available online at www.marchofdimes.com/peristats.) "All babies across America should be screened for all 29 of these treatable conditions," she said.

This is the fifth year the March of Dimes has worked with the National Newborn Screening and Genetics Resource Center to analyze

state-by-state newborn screening requirements.

Dr. Howse said the organization supports the Newborn Screening Saves Lives Act and the Screening for Health of Infants and Newborns Act of 2007, two bipartisan pieces of legislation that would lay the groundwork for national guidelines and authorize funding for education, improved follow-up care, and expanded programs. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Judge OKs Medicaid settlement plan

AUSTIN, TX—The 2.8 million-plus needy children in Texas' Medicaid program should have better access to checkups, timely prescriptions and other services under a court settlement approved by U.S. District Judge William Wayne Justice. That's the hope and prediction of children's advocates and state

officials who backed the settlement proposal. "The court concludes the proposed corrective action plan is fair, reasonable and adequate," said Justice. He's expected to sign a formal order later. Lawmakers budgeted a boost of nearly \$1.8 billion over two years—\$706.7 million in state general revenue and the rest in federal matching funds—for improvements including higher rates for doctors

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and dentists who treat youngsters under the Medicaid program. The rate hike is meant to increase the number of health care providers who treat children under Medicaid.

About one-third of dentists, and about 62% of doctors, serve Medicaid patients, said Health and Human Services Executive Commissioner **Albert Hawkins**. Although the number of doctors participating overall is higher than the number of dentists, the Texas Medical Association found only 38% of physicians accept all new Medicaid patients who seek care; another 26% limit the Medicaid patients they'll take; and 36% accept none. The legislature approved enough money for a 25% rate increase for doctors and 50% for dentists. But those working on the plan intend to target the funds at key services instead of giving a flat, across-the-board increase. That would mean bigger hikes for basic dental services such as X-rays and fillings and key physician services such as checkups and immunizations. The plan also addresses services including outreach; case management; timely answering of toll-free hotlines; ensuring needed prescriptions aren't held up just because the medicine isn't on the state's preferred drug list; and

provision of transportation.

— *Houston Chronicle*, 7/10/07

Delaware program targets uninsured children

DOVER—Delaware Insurance Commissioner **Matt Denn** is launching an effort to sign up an additional 1,000 children for the state's Healthy Children Program. About 5,000 of the estimated 10,000 to 12,000 children eligible for the program are currently enrolled. The program covers children 19 and younger whose parents earn too much to qualify for Medicaid but can't afford private insurance. Premiums range from \$10 to \$15 a month. Mr. Denn said he's set his target at 1,000 because that equals the amount of children who could be covered using federal money that goes unspent by the state and is sent back to Washington. If the program succeeds, Denn said it would cost the state about \$500,000 to meet its 40% share of the program's cost. "The situation now is unacceptable," Mr. Denn said. "About half the children who could be getting coverage through Medicaid or the Delaware Healthy Children Program aren't signed up....If we reach our goal, enrollment will increase by 20% but, whether we sign up an additional 50, 500, or 1,000 children, we will be improving their quality of life." Mr. Denn said his department will work with the state education department to seek children who take part in the free and reduced-price lunch programs, and through labor unions, churches, and community groups. The program will use volunteers who will go into churches, community centers, and neighborhoods to sign up families. He estimates the outreach program could cost up to \$160,000.

— *Wilmington News Journal*,
7/16/07

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